Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
DR. RONALD J. WASHINGTON

Respondent Name
ARCH INSURANCE CO

MFDR Tracking Number
M4-14-0435-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
OCTOBER 7, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The enclosed claim was reduced in error. This claim was for a Division ordered Designated Doctor Re-Exam."

Amount in Dispute: $347.04

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Based on the information received. Coventry stands by the review. Per review, the system is applying the multiple procedure correctly, as indicated on page 27 of the first link provided below. Under the 'Tiered reimbursement method for more than one non-MMI/IR examinations under the same order' section. No additional monies are due at this time."

Response Submitted by: Gallaher Bassett Services, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 28, 2013	CPT Code 99456-W6-RE Extent of Injury Evaluation	$250.00	$250.00
	CPT Code 99456-W7-RE Liability/Compensability Evaluation	$97.04	$97.04
TOTAL		$347.04	$347.04

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Texas Labor Code §408.027, effective September 1, 2007, sets out the rules for timely submission of a claim by a health care provider.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.204, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.

4. The services in dispute were reduced / denied by the respondent with the following reason codes:
   - 16-Claim/service lacks information which is needed for adjudication.
   - 59-Processed based on multiple or concurrent procedure rules.
   - W1-Workers compensation state fee schedule adjustment.

Issues

1. Does the documentation support billed service?
2. Is the requestor entitled to additional reimbursement for 99456-W6-RE, and 99456-W7-RE?

Findings

1. Based upon the submitted explanation of benefits, the respondent denied reimbursement for the disputed services based upon reason code "16." A review of the submitted Designated Doctor Evaluation report supports billed service; therefore, the respondent's denial based upon reason code "16" is not supported.

2. On the disputed date of service, the requestor billed CPT codes 99456-W6-RE, and 99456-W7-RE.
   - 28 Texas Administrative Code §134.204(i)(1)(C) stipulates "Extent of the employee's compensable injury shall be billed and reimbursed in accordance with subsection (k) of this section, with the use of the additional modifier "W6."
   - Per 28 Texas Administrative Code §134.204(i)(1)(D) the "W7" modifier is used for billing an examination to determine if the injured employee's disability is a direct result of the work-related injury and shall be billed and reimbursed in accordance with subsection (k) of this section."

   A review of the submitted medical billing finds that the requestor supported billing 99456-W6-RE, and 99456-W7-RE.

   The MAR for CPT codes 99456-W6-RE and 99456-W7-RE is:

   - 28 Texas Administrative Code §134.204(k) states "The following shall apply to Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. When conducting a Division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT Code 99456 with modifier "RE." In either instance of whether MMI/IR is performed or not, the reimbursement shall be $500 in accordance with subsection (i) of this section and shall include Division-required reports. Testing that is required shall be billed using the appropriate CPT codes and reimbursed in addition to the examination fee."

   - 28 Texas Administrative Code §134.204(i)(2) states "When multiple examinations under the same specific Division order are performed concurrently under paragraph (1)(C) - (F) of this subsection: (A) the first examination shall be reimbursed at 100 percent of the set fee outlined in subsection (k) of this section; (B) the second examination shall be reimbursed at 50 percent of the set fee outlined in subsection (k) of this section; and (C) subsequent examinations shall be reimbursed at 25 percent of the set fee outlined in subsection (k) of this section."

   The requestor is due $500.00 for the extent of injury examination; and $250.00 for the disability examination.

The Division finds that the total allowable for these examinations is $750.00. The respondent paid $402.96. As a result, the requestor is entitled to reimbursement of $347.04.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $347.04.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $347.04 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	10/20/2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.